HEALTH SYSTEMS
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DEPARTMENT OF PREVENTIVE MEDICINE AND BIOMETRICS

HEALTH CARE FINANCING ALTERNATIVES

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INTRODUCTION

The United States is one of the few advanced industrial democracies without some form of national health insurance. Our current system of health care financing has evolved due to a variety of influences, including cultural, economic, institutional, and political factors. In this era characterized by rising health care costs and increasing numbers of uninsured individuals, public opinion calls for major health care reform, but falls short of asking for a universal entitlement program. American individualism simultaneously reinforces both a reluctance to provide government programs for able-bodied working citizens and a distrust of government solutions to societal problems. Policy makers opposed to national health insurance and like-minded interest groups have exploited citizens' ideas about the proper scope of government authority to create fears about "big government" and waste. Although millions of people in the United States have no health insurance, one obstacle for reform is the simple fact that a substantial majority of the population either has employer-provided health insurance or enough income to purchase health insurance. Although America's founding fathers declared the pursuit of happiness (inherently including the pursuit of health) to be a basic human right, they forged a political institution that was explicitly designed to pit faction against faction to protect minority factions from majority factions. American politics is so prone to stalemate that comp□ehensive reform is nearly impossible.

The ongoing debates about consumer and governmental roles and responsibilities, relationships between cost and quality, and the effects of financing systems and managed care on health care delivery, are occurring as medical costs continue to rise and insurance plans cover less and less while charging higher premiums. As Americans are increasingly unable to pay higher premiums, they become part of the growing uninsured public, leading to an even greater health care cost burden on individual states and the federal government. Uninsured patients receive minimal health care, waiting until their health deteriorates before seeking medical intervention. This increased disease severity also places upward pressure on health care costs. Central to the debate is whether free market or government-driven strategies should be used to control health care expenditures.

Three sources exist for health care financing: the government, employers, and individuals. This paper discusses the advantages, disadvantages, and barriers of each financing source, examining potential financing mechanisms or plans within each category.

FINANCING MECHANISMS

Single Payer—The Federal Government

The federal government already pays for over half of health care provided in America today. As noted above, expansion of coverage to provide care for everyone regardless of employment status is a politically and culturally unpopular choice. Because the liberal tradition of individualism has deeper roots and more political impact in Anglo-American countries than in other advanced industrial democracies,[1] it is likely that national health insurance, if implemented in the United States, will more closely resemble the United Kingdom's or Canada's plan than other plans. Ultimately, financing for national health insurance is funded through taxes on individuals and employers.

[1] Blake, H.S. and Adolino, J.R. 2001. The Enactment of National Health Insurance: A Boolean Analysis of Twenty Advanced Industrial Countries. *Journal of Health Politics, Policy and Law.* 26(4):679-708.

ADVANTAGES
- Avoids a "two-class" system of care, provides coverage for everyone, regardless of economic status
- Minimizes administrative cost per dollar reimbursement

DISADVANTAGES
- Moral hazard. Lack of individual financial accountability results in overuse of health care system
- Increases tax burden to support health care
- Government programs tend to be less efficient
- Decreases consumer choice
- Decreases availability of high cost medical care

BARRIERS
- Impact on current stakeholders, especially insurance companies
- Cultural, social and political inertia

One financing mechanism recently examined for national health coverage that attempts to address moral hazard is the Medical Savings Account (MSA). This mechanism, similar to one used in Singapore, is structured on a specific wage contribution, based on a percentage of every dollar earned, to a MSA. Just as Social Security contributions are deducted from wages regardless of type of employment (full time part time, flex, self-employed), MSA contributions would be mandatory. A minimum required contribution equal to a base premium that would provide a certain level of health care, including preventive services such as vaccinations and yearly physicals. Individuals could voluntarily contribute more to increase the level of coverage or prepare for future changes like children, etc. There could be open seasons, every six months, wherein employees could select higher or lower levels of covered care. Employees would have health care insurance for life. This coverage would be portable and continuous—including periods of unemployment. Federal and state governments would subsidize the difference for individuals unable to afford the minimum coverage. As individuals retired, they would roll over to Medicare and could use their MSA to purchase supplemental plans. These would be tax deductible for employer, self-employed or individually purchased plans through the government.

ADVANTAGES
- Premiums equal across the working population, small business, large business, self-employed, part-time employed
- Portability. Travels with worker when worker changes jobs
- Allows workers to build up amount for future use—getting married, retiring and use as supplement to Medicare
- Focuses on preventive care and health education to minimize costs
- Increases freedom of choice but may have to pay difference of costs
- Addresses concern over moral hazard

DISADVANTAGES
- Establishes "multi-class" system of care. Impoverished only receive minimal coverage
- Rations care, setting limits on certain services.

BARRIERS
- As above. Impacts stakeholders. Drastic changes unlikely

Employer-sponsored Financing

Employer-sponsored health insurance began with coverage for hospital and physician's services. It currently funds about one-third of personal health care expenditures. Historically, this insurance took the form of indemnity plans. Managed care, including health maintenance organizations received an increasing proportion of employer health care dollars over the past two decades.

ADVANTAGES
- Viewed as a "right" by employees
- Substantial tax breaks for employers providing health insurance
- Increased employee productivity

DISADVANTAGES
- Mounting health care expenses increase the cost of doing business and decrease global competitiveness
- Moral hazard. Lack of individual financial accountability results in overuse of health care system

BARRIERS
- Regulatory changes have increased employer liability, making employer-sponsored health care legally and administratively more complex.

A study done by the Kaiser Family Foundation found that employers face double digit (12.7%) rate increases in insurance premiums. Premiums reached new plateaus this year: about $3,000 for single coverage and $8,000 for a family. These increases were attributed to increased prescription costs and hospital care for an aging population. As a result employers are cutting benefits and raising employee costs (higher deductables, co-pays for prescriptions). Out-of-pocket expenses average $454 per year for a single individual and $2,084 per year for a family. Coverage for retirees and small-business employees is vanishing. Nine percent of large employers (200 or more employees) have eliminated retiree benefits for new hires and existing employees. This is expected to rise to 11% within two years. Small employers (3 to 199 employees) offering coverage have dropped from 67% in 2000 to 61% in 2002. Due to mounting employer health care costs, the most recent focus has been on defined contribution plans (DCPs) where the employer provides a voucher for services or makes a contribution to a MSA.

ADVANTAGES
- Allow employers to provide a base level of health care insurance for employees while decreasing their expenses, liability, and administrative costs
- Allow employees to have more control over the type of health care chosen, increasing satisfaction with health care benefits
- Thought to constrain health care cost inflation

DISADVANTAGES
- Although beneficiaries would be provided with appropriate tools to support decision-making, they may not possess the level of sophistication to use them and may make poor choices
- Doesn't address the problem of coverage for the unemployed or uninsured
- Appears to be stopgap measure. If health care cost continues to rise, consumer would be responsible for paying more and more for the same level of care.
- May still require government tax subsidies for certain income levels.

Individual-financed Health Care

Health care financed by individuals is that portion of care where the consumer pays directly for services. Uninsured consumers pay for health care in this fashion. Insured consumers pay deductibles or for uncovered services in this fashion. In defined contribution scenarios, additional coverage would be purchased directly by the consumer. In-as-much as employer-provided MSAs or vouchers could be considered compensation, individually-purchased health care plans using vouchers or MSA contributions, can also be considered in this category.

ADVANTAGES

- Allows greater freedom of choice
- Eliminates moral hazard
- Vouchers could be used to provide tax incentives for families purchasing private health insurance.

DISADVANTAGES

- Does not address the issue of providing health care for the unemployed and medically indigent.
- Individuals must finance their healthcare needs from their own resources. When these funds are insufficient, individuals must do without or rely on charity care
- If paying directly out-of-pocket without purchasing insurance, the health care consumer may be expected to pay the list price, potentially increasing the cost of health care

PROPOSED ALTERNATIVE HEALTH CARE PLAN

Because of the reasons outlined in the introduction, we consider the adoption of a single-payer national health insurance to be unlikely. Instead of a teutonic shift in the health care funding mechanism, we believe that small incremental changes in current mechanisms are most likely. Because current financing is built on the framework of employer-financed health care, we have decided to focus on an employer-based plan: A Medical Savings Account through a Defined Contribution Health Insurance Program (DCP). This may not end up as the eventual funding mechanism, if there ever is one, but it is the most likely to be adopted by the current system. It has a familiar ring; consequently, people are more likely to be accepting of it.

The concept behind a DCP is that employers would continue to contribute a specific amount to an employee's health insurance plan, in this case a health spending account. From this account, the employee buys a health insurance policy. Any money remaining would stay in the account. This money would roll over into the next year and would follow the employee, even if he/she changed employers. The employee could use this money to purchase other health services not covered by the insurance policy. The employer would no longer choose the plan and this would decrease an employer's liability. The employee would bear the responsibility for choosing the insurance provider, the level of coverage, health care providers, choice of services, deductibles, and co-payments. Unwise choices by employees would lead to failure of this type of plan. The employee uses the Internet to determine costs of different services, make decisions about health care, and to monitor his or her health spending account. The goal is to make consumers more aware of health care costs and use health services more appropriately, eliminating moral hazard. It is proposed that employees will be more satisfied with health care benefits, use medical services more appropriately (spend their own money) and ultimately reduce employers' administrative costs.

Policies and regulatory changes that need to be in place for plan to be effective

- The concepts of ERISA need to be reinforced and strengthened to continue liability protection for employers and establish uniform standards. With this support employers can provide insurance and maintain benefit plans under a single set of rules, instead of multiple and different state standards which may conflict with federal standards and vary with jurisdiction.
- Uniform standards are essential to improve organization of health care delivery; quality and outcomes management; confidentiality; market conduct; administrative procedures; capitalization; consumer protections; financing; cost containment and claims dispute resolution. Having consistent and uniform standards will decrease competition between states.
- Pass tax law changes to allow tax deductions for employers providing health care insurance, self-employed individuals, and employed individuals who choose higher level plan.

- Liability limits placed on malpractice lawsuits nationwide. Establish arbitration boards to review and toss out frivolous lawsuits. A recent review showed that some states, Illinois, for example, have almost a three-fold increase in malpractice insurance costs due to state laws.
- Individual responsibilities and "rights" need to be standardized. Some things are not a right; we must earn or pay for them. We cannot expect the public to pay for our irresponsible choices: smoking, drinking excessively, drug use, eating too much, and not exercising to mention a few.
- The Federal government needs to set limits, based on geographic regions, on premium costs, especially for minimum health care coverage.
- The myriad of state and federal regulations dictating current coverage will have to evolve if the transformation from a defined-benefit system to a defined-contribution system is to be successful.

How this proposal will affect other government healthcare programs

- This is difficult to predict. We believe they will stay the same initially. It would be unwise to attempt to change other programs until the effects of a new health care plan are vetted. There may be less money required for some of the programs, if people are better insured from the beginning and kept healthier, requiring less costly care.
- Health care systems currently available to the military and veterans should not change. The overall health in these populations might even improve if they had a healthcare plan in place before entering the military or contributed to one during their career to supplement their retirement medical benefits.
- Federal employees have plans that should not be affected. Alternatively, they could opt for a DCP type of plan, increasing overall enrollment and lowering premiums in general.
- If the employer-based plans should fail and premiums continue to rise, federal and state governments will need to finance more health care costs, affecting all government-based programs by default.

CONCLUSION

Regardless of the plan chosen, there are going to be some major adjustments for everyone involved: the public, employers, insurance companies, and health care providers. The entitlement to the most advanced technologies, procedures, and pharmaceuticals is in question. In an era of limited resources, we need to accept rationing as part of our health care reality. People will have to pay full price for cosmetic surgeries and a significant portion of major procedures unless they have purchased the highest level of available health care coverage. Even then, a co-payment will be required.

Our consensus is that continuing employer-based financing is just a stopgap measure that is more palatable to policy makers, providers, the insurance industry, and even a majority of the public at this time. Ultimately, due to drastically rising premiums, employer-based health care plans will force people to go uninsured and increasingly dependent on state or federal assistance for health care. We feel that a National Insurance Plan needs to be developed for people to buy into, regardless of working status. The federal government will need to subsidize certain income levels to ensure ability to purchase insurance. Preventive care should be provided at no cost to recipients at state or federally run clinics. Our government will need to impose caps on premium costs, services, and types of services provided under the plans available.

Whether a result of default or initiative, what ultimately emerges as the system of financing of health care in the United States will be radically different for the payers, consumers, and providers of care from the systems that were its predecessors. The goal should be to provide a minimum of health care and health education to everyone. The healthier we are as a society, the less we collectively pay for health care.